

Finding No. 1

The Department of Social and Health Services, Division of Vocational Rehabilitation does not have adequate internal controls over the processing of expenditures for client services.

Department's Response:

The Department concurs with the finding. The Division of Vocational Rehabilitation will perform the following to address the auditor's recommendations:

- The division will establish internal controls for the separation of duties within the STARS system. The STARS system will be updated to electronically ensure separation of duties are maintained beginning with the application phase. In terms of warrants sent to the originating office, the division will strengthen the cash controls and provide training to ensure separation of duties for the handling of cash items.
- The division will update the Supervisory AFP review policy. The division will also establish a STARS automated report to include STARS exceptions for Supervisors and Chiefs to review.
- The division will strengthen the cash controls policy and provide training to staff. The division will also establish policy for how small offices of 3 or less staff will handle cash controls.
- The division will establish a customer travel policy to include when receipts or certifications are required when purchasing customer travel such as mileage, meals and lodging payments. Procedures will be established to include what's required on the authorization for purchase (AFP) for proper documentation of what is being purchased.

Finding No. 2

The Department of Social and Health Services, Mental Health Division does not have sufficient internal controls over drugs in Western State Hospital pharmacies to prevent and/or detect misappropriation or loss.

Department's Response

The Department partially concurs with this finding.

Automated Drug Distribution Devices

WSH concurs with this condition. The two currently used devices will be replaced with four automated med-stations (Pyxis med-stations) by the end of January 2003. The med-station devices will electronically track the drug inventory and distribution activities. Each licensed staff member who is authorized to use the med-station device will be required to sign-on using a unique password specific to each licensed staff and also be required to provide its respective "bio-ID" (fingerprint). The med-station device will record who accessed the machine, the date and time, strength and quantity of each medication requisitioned, as well as the patient's name. The devices will also provide critical medical information specific for each patient. Additionally, when a controlled substance is requisitioned, the user will have to verify the physical count of the medication for each occurrence. Discrepancies will automatically flag both the med-station device and a console in the main pharmacy electronically. The supervising nurse for the shift will be required to resolve the discrepancies at the time they are discovered.

WSH is seeking Legislative funding to install a new med station on each ward by July 2004.

Accountability of Drugs

Working stock:

WSH does not concur with this condition.

WSH is currently in compliance with State Board of Pharmacy law and pharmacy standards regarding "working stock" processes and procedures. "Working stock" is kept in locked cabinets and is only accessible by licensed Pharmacists. With regard to the State Auditor's recommendation, WSH does not have the resources and/or updated technology to currently meet the requirements. However, WSH has requested Legislative funding for automated devices, which will electronically monitor the activities regarding "working stock". This problem will be eliminated once funding is approved and installation is completed.

Due to lack of resources and insufficient technology, drop boxes are currently used. These boxes are locked and accessible by individuals who have access keys. Only one nurse on each ward has access to that ward's box. Similar to the installation of the new

devices for “working stock” drugs, the installation of these machines will eliminate the need for “drop boxes”.

Drug Returns:

WSH does not concur with this condition.

Each weekday more than 1,000 tablets/capsules are returned to the main and satellite pharmacies. The most common reasons for returns include discharge of a patient, discontinuation of a medication, change in dosage, placement of patient on authorized leave, dosage refused by patients, etc. If the returned medication is in useable condition, it is returned to the shelves for redistribution. However, because of limited resources and technology, WSH does not have the capacity to track these returns on an ongoing basis.

Automated med-station devices will solve this issue. Medications in the med-station devices will not be labeled for individual patient use; rather it will be in a controlled inventory sorted by drug type. Each dose of medication added or removed by a nurse will be electronically increased or decreased from the inventory. Medications, which have been discontinued or changed per Physician order, will still be in the med-station inventory and will not be required to be transported back to the main and satellite pharmacies.

Non-Narcotic Prescription Refills:

WSH does not concur with this condition.

There are several reasons for these refills to be requested in large variations. Reasons include dropped tablets and patients who spit out the dose and require re-administration of the medication. Another reason for refills is the large volume of internal patient transfers within WSH. A patient transferring from one ward, who receives their 7-day refill on one day, to another ward, who gets their 7-day refill on a different day, may require additional medication to get them through to the transition to a new delivery day.

Through data gathering, the Pharmacy Department recently determined that the Pharmacy 7-day refill delivery schedule for the wards was causing some “early refills” requests. After some internal pharmacy system configuration of the timing of delivery of the refills, the problem has been eliminated. The Pharmacy and Nursing Departments also gathered data and evaluated the types of medications that are most commonly requested for an “early refill.” Through a collaboration effort, they found that antipsychotics and anticonvulsants were the medications most often requested. These do not represent the type of medications that are most likely to be diverted and refills are more likely due to reasons mentioned above.

Overall, the number of refill requests has decreased by 15% over the past year by streamlining the process, educating nursing staff and adjusting the refill delivery

schedule. Efforts continue to retrieve additional data from nursing staff on the wards for further efficiencies. Additional improvements will be implemented after further data is collected and analyzed.

When automated med-station devices are funded and installed on all wards, patient-specific refills will be eliminated and each dose removed will be recorded electronically.

Finding No. 3

The Department of Social and Health Services, Division of Child Support did not have adequate supporting documentation for printing and payroll costs.

Department's Response

The Department concurs with the audit finding.

Printing Costs:

Since the time of the Auditor's initial review, the Division obtained Job Cost Sheets from the State Printer for 32 of the 51 invoices referenced above. These Job Cost Sheets were not available at the time of the auditor's initial testing of the State Printing payment batches for March 2002. In a second review by the auditors of the State Printer March 2002 batch; the auditors approved the use of the Job Cost Sheets as adequate payment documentation. In the cases where Job Cost Sheets did not apply, the purchase orders from the State Printer were used to verify the invoices. These include printer paper orders where the paper is acquired by the State Printer through a bid process. The Division now requires Job Cost Sheets and/or State Printer purchase orders for all State Printer invoice billings.

The Accounts Payable desk manual will be revised to include procedures for correctly handling the nondescript invoices and what is the acceptable form of invoice to document what has been received for payment.

Payroll Costs:

A Corrective Action Plan has been developed and implementation has begun. As part of the Corrective Action Plan, the Division of Child Support (DCS) will review federal regulations regarding staff charges, establish time and effort documentation where necessary.

Finding No. 4

The Department of Social and Health Services, Economic Services Administration does not perform adequate or timely reviews to ensure the allowability of child care payments made to clients and vendors from federal and state funds.

Department's Response:

The Department concurs with the finding. The Economic Services Administration concurs with the auditor's finding that previous corrective action plans developed to ensure the performance of adequate and timely reviews of childcare payments were not sufficiently implemented nor monitored.

The Division of Child Care and Early Learning (DCCEL) and the Community Services Division (CSD) have issued a joint memo to regional management staff requiring the immediate implementation of the required supervisory reviews. DCCEL headquarters staff will monitor the reviews on a monthly basis and provide the CSD Director with routine reports on the compliance status of Community Service Office and Regional Office monitoring efforts. In addition, the CSD Director has established supervisory childcare case audits as one of nine performance issues to be monitored with Regional Administrators. Issues of non-compliance will be discussed with respective Regional Administrators during weekly phone calls designed to monitor regional performance in the identified performance areas. The Directors of the DCCEL and CSD will present additional oversight measures that address the training issues in the final corrective action plan established in response to the auditor's finding.

With regard to Working Connections Child Care questioned costs identified by State Auditors Office (SAO), we would like to add some additional information. As SAO describes in the finding, part of our corrective action plan was to have the internal audit staff complete five audits of child care providers. The Office of Review and Consultation (ORC) did these five audits; three had overpayments and two had underpayments with a total overpayment of \$48,917.98. Rather than address only these five audits, which were part of the agency's corrective action plan, SAO included seven ORC audits conducted over a three-year period (which includes a period outside of the agency's corrective action plan and fiscal year 2002). SAO's decision to include audits covering a three -year period, rather than the five audits conducted as part of the Corrective Action Plan skews the over-all picture. Therefore the actual questioned costs as part of the fiscal year 2002 audit should be stated as \$48,917.98, not the \$424,000 that is identified above.

The department will identify the funding sources in question and complete necessary collection action.

Finding No. 5

The Department of Social and Health Services, Economic Services Administration, is not in compliance with eligibility requirements for the Temporary Assistance to Needy Families Program.

Department's Response:

The SAO audit involved three program areas; TANF income eligibility, validity of Social Security numbers used by recipients, and receipt of benefits by incarcerated persons.

Economic Services Administration concurs with the auditor's finding that it should use available information, some gathered and maintained by other State agencies, in periodic comparisons of client/recipient information. Discrepancies should be investigated and payment errors corrected. Improved use of technology and automation will aid in the detection of cessation of incorrect payments.

CSO field staff has a means available to validate SSN information. Operationally, we can manually verify questionable SSNs if necessary though a labor-intensive process. The solution and Corrective Action Plan (CAP) will address staff training on existing processes. All financial staff will be required to attend system interface and alerts training.

- Local office staff already knew of several of the TANF income eligibility discrepancies prior to the auditor visit and corrective payment actions were in process.
- The automated eligibility system does run income related cross-matches on cases when a review is initiated. Reduced staffing levels may have contributed to staff's inability to react to all potential claims timely. ESA is exploring the possibility of contracting with "TALX", an automated system that instantly provides wage-based income verification.
- The automated alerts occur at application and every 5 months thereafter if the number is an error. ACES interface and alert training will help significantly as well as making the Social Security on-line query (SOLQ) process simpler.
- We are investigating the feasibility of building a cross-match to Department of Corrections data. Experience has shown that our clients often are incarcerated for short periods of time and their eligibility for benefits is unchanged. We will continue to gather information on this issue.

Finding No. 6

The Department of Social and Health Services, Economic Services Administration, did not comply with federal cost principles for charging terminal leave payments.

Department's Response:

The Department concurs with this finding.

As of the end of fiscal year 2002, the division had not completed its corrective action to ensure compliance with the federal requirements. Since then, necessary steps have been taken and implemented to ensure that fiscal year 2003 is in compliance. With regard to the questioned costs in the amount of \$37,673, the division will reallocate the terminal leave payments according to the required methodology.

Finding No. 7

The Department of Social and Health Services' Medical Assistance Administration has not established sufficient internal controls to ensure compliance with Medicaid provisions.

DEPARTMENT'S RESPONSE:

The Department partially concurs with the conditions noted in this finding.

Condition A. Payments made for persons with invalid social security numbers or made on behalf of deceased individuals.

The Department does not concur with this condition. Based on the data and research of both the Department and the SAO, the total questioned costs should be stated as \$48,854 rather than the \$819,887 as shown above. The reason for the difference is that SAO used a different test database and criteria when testing records in the following two areas:

- **The Department does not agree with the audit exceptions for recipients classified as deceased and receiving benefits.** The department uses Social Security Administration (SSA) data to determine if persons are living or dead. For audit testing, the SAO used a system called VERIS, a commercial software package from Security Software Solutions (SSS), trademarked by S.G. Schoggen and Company. The VERIS package allows its customers (in this case, the SAO) to obtain Social Security number validation from Security Software Solutions, which gets information from SSA updated weekly. VERIS does not directly link to the SSA databases and Social Security Administration has repeatedly advised the Department to rely on data obtained directly from their databases, instead of secondary data sources such as those used by the SAO.

To determine date of death, the SAO appears to have used the SSA Death Master File Index. However, DSHS found that persons listed as deceased on the SAO index were continuing to receive SSA and SSI benefits, according to the SSA databases and Master Benefits Record¹. The SAO refused to accept SSA payment information as evidence the recipient was still alive, despite the fact that the Department is required to accept such information as stated in [42 CFR 435.955](#). SAO also refused to accept any other collateral evidence, such as department visits to the home, facility statements of the person being alive, or statements from relatives and the recipient's identification.

If DSHS receives information that conflicts with the SSA data, DSHS independently verifies the correct data. This allows DSHS to use the most accurate data in making their determinations, while complying with federal rules by using the SSA interface information. SSA states that the best source of data is SOLQ, which is real-time, accurate information as SSA records it. Using SSA data complies with 42 CFR 435.948, which requires State Medicaid agencies to interface with Federal agencies and use their data to make eligibility determinations.

¹ SSA instructed DSHS to rely on these sources of information as more accurate than the data in the SSA Death Master File.

The Department has complied with federal law in obtaining and verifying the questioned SSNs, and would have no authority under federal law to rely upon the database accessed by the SAO.

- **The Department does not concur with the findings on invalid social security numbers.** The Department does agree that there are instances of recipients receiving benefits with incorrect social security numbers but this occurs under the Federal requirement (42 CFR 435.910(f)), *“The agency [in this case, DSHS] must not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by SSA.”*

By Federal law, DSHS is prohibited from refusing benefits to possible ineligible while waiting for issuance or verification of an SSN. This puts the state in the position of issuing benefits without verification of an eligibility factor, as required by federal law, and then having associated costs questioned by the SAO.

In addition to the questioned costs, DSHS would like to provide additional information regarding some of the recommendations from the SAO. It is not possible for DSHS employees to review all alerts all the time given the current workload. However, we do think it is possible to provide training on the SSA interface systems and SSA alerts. The department does recognize there are system problems that adversely affect employee case review productivity. Specifically, the SOLQ tool needs improvements to its sign on process and accessibility to staff. It is a useful tool but has program flaws that inhibit the work process

Additionally, there are also SSN errors attributable to the conversion from the old system (ITIS) to the current eligibility system (ACES). The Department is looking into the possibility of the ACES producing quarterly SSN reports in order to do a comprehensive SSN review. If this can be accomplished in addition to SOLQ tool improvements, DSHS will be able to reduce some manual processes and improve case reviews.

The Department does not concur with “Other Exceptions Not Included in Sample.” The department was not provided information on the cases that pertain to the \$17,705 during or after the audit, therefore we cannot determine if these questioned costs are valid.

Condition B. Basic Health Plus

The Department does not concur with this condition. In the prior year audit response we stated that the audit test results did not support the need for a finding. In this follow up audit year, audit testing was not done and does not support additional audit recommendations. We reaffirm our SFY01 audit response with additional clarification to statements made in this audit finding:

- All applicants and recipients are expected to declare their household income, regardless of whether their income is at or below 200% Federal Poverty Level (FPL).
- In addition to the 400 BH Plus random reviews, Medical Eligibility Determination Services (MEDS) receives an average of 1,200 BH Plus Household Change (DSHS 14-406) forms

from households due for an annual review monthly. The 1,200 is based on the fact that three maintenance units receive between 400 – 450 DSHS 14-406 forms returned by clients each month. Each change form is reviewed by an eligibility worker to determine if the change affects continued eligibility.

- MEDS has always corroborated a client's income declaration if the declared income is at or above 200% FPL, by pending the application or review and requesting proof of income.
- Changes in income do not affect a child's Medicaid eligibility during their certification period.
- There is not a requirement to verify income unless it is questionable. Self-declaration of household circumstances is provided under MAA's policy distributed to the field on December 3, 1998. DSHS is notified of household by BH or via the DSHS 14-406 form.
- MEDS does work with HCA on reported income changes during the certification period and is followed up at annual review time. It is an expectation for both Basic Health (BH) and Medical Assistance Administration (MAA) staff to follow Chapter 5, section 5-02 Basic Health Plus Pregnancy Medical Change of Circumstances – Change in Household/Income in the BH/MAA Policy and Procedure Manual.

With regard to the new audit recommendations from the SFY02 audit:

a. **Require declarations of income for all clients not just those close to 200% FPL.**

DSHS could not do more than it is already doing to verify client income. All clients applying for children's medical are required to declare their income on the application. DSHS policy requires all applicants requesting children's Medicaid to declare their household income, regardless of whether it is "close to 200% FPL". December 3, 1998, DSHS established the policy of declaration of income for children's medical programs. Those guidelines stated: ".....children applying for medical programsmust declare income on the application."

b. **Establish procedures that would corroborate a client's income declaration with an independent source.**

MEDS follows established DSHS policies for corroborating client income as outlined in the Eligibility A-Z Manual, WAC 388-406-0030 (3); WAC 388-490-0005 (2), (3), (4), (5) (a), (b), (c), (8) (a), (9), (10); WAC 388-458-0001; Clarifying Information (E A-Z manual, pg 4 & 5), "The federal requirements for Medicaid verifications are much less stringent than those for cash or food assistance. Except as noted in the chart below (see E A-Z manual) for specific programs, accept client's declaration of age, identity, and SSN. Ask for verification to be provided whenever the information is questionable." The chart specifically indicates that for children's Medicaid, we do not require verification unless questionable. For verifications, "Any source, including verbal, written, and email statements, can be used as long as it meets the "Criteria for Evaluating Verification" (see E A-Z manual). Income can be verified via pay stubs, statement from employer, SEMS data, bank statements, collateral contact, SOLQ. These procedures are already established and staff follows them in order to corroborate a client's income declaration if necessary.

Condition C. Provider Licensing

The Department did not concur with this finding in the SFY01 audit, nor do we concur with it for this fiscal year. We previously acknowledged that enhancements to the division's internal controls and procedures could be made and the Department has done that. Post audit review of the providers questioned in the SFY01 report showed all were properly licensed in the audit period tested. The Department reaffirms its response to the SFY01 and emphasizes that the \$9,837,143 questioned was for properly licensed providers and should not have been cited as a questioned cost.

Condition D. Provider Health and Safety Standards - Hospitals.

The Department concurs with this condition. MAA plans to establish procedures that will be used when information comes from DOH, Aging and Adult Services or other established entities regarding health and safety standards not being met. However, given other priorities and the lack of additional staff, this area has not been addressed at this time.

Condition E. Provider Health and Safety Standards – Nursing Homes.

The Department concurs with this condition. However, the department believes a more effective method of tracking Denial of Payment Notice (DOP) is for CMS to directly notify MAA of the facility status. Corrective action has been identified and was implemented in November 2002.